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PAPERS EXAMINING CRITICAL ISSUES
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Senate Fiscal Agency

THE ROLE OF MEDICAID SPECIAL FINANCING IN CHANGES IN STATE EXPENDITURE 1991-2007

by

David Fosdick
Fiscal Analyst

January 2008

Gary S. Olson, Director – Lansing, Michigan – (517) 373-2768 – TDD (517) 373-0543
www.senate.michigan.gov/sfa

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Gary S. Olson, Director
Senate Fiscal Agency
P.O. Box 30036
Lansing, Michigan 48909-7536
Telephone (517) 373-2768
TDD (517) 373-0543
Internet Home Page http://www.senate.michigan.gov/sfa

ACKNOWLEDGMENTS

The author wishes to thank Steve Angelotti with the Senate Fiscal Agency for his help and Mary Jane Russell with Department of Community Health and Farah Hanley with the Office of State Budget for their cooperation in researching this paper.

TABLE OF CONTENTS

INTRODUCTION

A significant factor in the growth of General Fund/General Purpose (GF/GP) expenditure in the State of Michigan over the past 10 years has been the rapidly increasing cost of operating the State's Medicaid program. This increase in cost is largely linked to rising program caseload in Michigan as well as recent growth in the cost of providing health services.

Another factor contributing to Medicaid GF/GP cost increases in Michigan, which has received little attention, is the diminished ability of the State to make use of Medicaid special financing. Since the early 1990s, Michigan has been able to exploit loopholes in Federal law that permitted the State to generate additional Federal matching funds for Medicaid through complex payment arrangements with public medical providers. Use of these payment arrangements has permitted the State to reduce its GF/GP Medicaid expenditure by billions of dollars over the past 16 years. As the Federal government has closed these payment loopholes, Michigan has been forced to allocate more GF/GP dollars to support the Medicaid program.

This paper will explore the role that special financing has played in the State's Medicaid expenditure since 1991 and the impact that the loss of these techniques has had upon GF/GP growth in Medicaid since 2002.

SPECIAL FINANCING STRATEGIES

Michigan has made use of several payment techniques to increase Federal financial participation in Medicaid. Provided below are a brief explanation of how each of the special financing techniques was structured and an estimate of the GF/GP savings associated with use of each of these payment mechanisms.

Disproportionate Share Hospital Payments

Federal regulations permit State Medicaid programs to make supplemental payments to hospitals that provide a high proportion of their care to Medicaid recipients and the uninsured. These payments, known as disproportionate share hospital (DSH) payments, are similar in structure to Medicaid reimbursement for health services. State financial contributions are matched by Federal Medicaid funds at the Federal Medicaid Assistance Percentage (FMAP) rate. States are subject to an annual cap on DSH payments; this cap is determined by historic state DSH spending with some allowance for inflationary growth.

Because DSH payments are not reimbursement for specific services, states have some flexibility in how they are used. For example, Michigan has made use of DSH payments to make funds available to safety net hospitals and public medical education programs, and to finance a county-administered low-income health benefit. Michigan also has used DSH payments as a tool to reduce GF/GP expenditure in the Medicaid program. The State has accomplished this in the two ways described below.

Payments to Public Hospitals

From fiscal year (FY) 1990-91 to FY 2004-05, the State used a portion of its DSH allocation to make payments to the University of Michigan Medical Center, Hurley Medical Center in Flint, and a few smaller public hospital facilities. The GF/GP portion of this payment was returned to the State along with the Federal matching funds; these Federal funds could then be used to support the base

Medicaid program, creating GF/GP savings. Table 1 provides some information on the GF/GP savings achieved by the State through use of this technique.

Table 1

Public Hospital DSH GF/GP Savings	
Fiscal Year	*Annual GF/GP Savings*
1990-91	$200,000,000
1991-92	$233,500,000
1992-93	$255,523,800
1993-94	$314,703,600
1994-95	$47,175,900
1995-96	$34,463,100
1996-97	$14,488,000
1997-98	$33,396,400
1998-99	$40,777,000
1999-2000	$31,552,600
2000-01	$39,965,800
2001-02	$34,575,200
2002-03	$37,229,800
2003-04	$69,551,800
2004-05	$45,805,700
Total	**$1,432,708,700**

Source: State Budget Office

Changes in Federal law enacted in 1994 reduced the scale of the public hospital DSH program and a further change passed in 2001 modified how available funding for payment is calculated. This change, phased in by FY 2004-05, made using this technique difficult for the State of Michigan to continue, and is the reason that public hospital DSH payments are no longer made.

State Psychiatric DSH Payments

State psychiatric facilities are largely supported by State and local payments. Federal Medicaid regulations prohibit Medicaid payments made on behalf of individuals in institutions (correctional facilities and most psychiatric hospitals). The Federal government does permit DSH payments to be made to state psychiatric hospitals, however. Federal matching funds associated with State DSH payments replace GF/GP dollars that would be necessary to support these facilities, so the Federal portion of the payment represents GF/GP savings to Michigan. Unlike other special financing techniques, both the State and Federal portions of these payments are retained by the providers to support the facilities' operations.

Disproportionate share hospital payments to State psychiatric hospitals were first made in FY 1994-95 and continue to this day. The size of the DSH payment made to psychiatric facilities is constrained, to some extent, by Federal regulations. Changes in Federal regulation of DSH payments to state facilities reduced Michigan's GF/GP savings associated with State psychiatric DSH payments in FY 2000-01. Table 2 provides a summary of GF/GP savings the State has enjoyed through use of State psychiatric DSH payments.

Table 2

State Psychiatric DSH GF/GP Savings	
Fiscal Year	*Annual GF/GP Savings*
1994-95	$173,234,400
1995-96	$136,815,700
1996-97	$127,576,000
1997-98	$113,040,900
1998-99	$103,548,700
1999-2000	$135,460,400
2000-01	$122,647,500
2001-02	$100,669,000
2002-03	$71,009,400
2003-04	$79,313,100
2004-05	$75,475,100
2005-06	$80,306,500
2006-07 (est)	$80,008,500
Total	**$1,399,105,200**

Source: State Budget Office

Intergovernmental Transfers/Adjustor Payments

While states determine the rates paid to medical providers for Medicaid services, Federal regulation establishes a ceiling on total Medicaid reimbursement that can be allocated to any participating Medicaid provider. This standard, known as the upper payment limit (UPL), is tied to rates paid through the Federal Medicare program. In Michigan, Medicaid reimbursement is in many cases far lower than that provided by the Medicare program. The disparity between Medicaid reimbursement rates and the Federal UPL created opportunities for the State to make supplemental special financing payments to some medical providers as a way to generate GF/GP savings. This technique was used by the State in three separate efforts: payments to hospitals, payments to some long-term care providers, and payments to local mental health agencies.

This type of arrangement was the target of changes in Federal rules on how the UPL may be calculated and how funds paid to public facilities could be used. Rule changes imposed by the Centers for Medicare and Medicaid Services in 2001 and 2002 significantly restricted the ability of states to make use of this special financing arrangement, which was phased out, for the hospital adjustor and long-term care adjustor payments, by FY 2004-05.

Outpatient Hospital Adjustor Payments

Between FY 1993-94 and FY 2004-05, the State provided GF/GP funding to participating public hospitals to account for the difference between statewide Medicaid hospital outpatient reimbursement and the amount of reimbursement that would be provided if Medicaid rates were set at the Federal UPL. These payments were matched at the Federal FMAP and then returned along with the initial GF/GP grant to the State through an intergovernmental transfer (IGT). The Federal portion of this payment could be invested in the Medicaid program, reducing the need for GF/GP support for the Medicaid program. Table 3 provides a summary of the savings generated through this technique.

Table 3

Hospital Adjustor Payments GF/GP Savings	
Fiscal Year	*Annual GF/GP Savings*
1993-94	$22,548,000
1994-95	$69,625,200
1995-96	$115,476,400
1996-97	$107,916,000
1997-98	$120,374,100
1998-99	$123,529,000
1999-2000	$188,448,600
2000-01	$188,545,000
2001-02	$189,210,000
2002-03	$133,447,800
2003-04	$93,291,000
2004-05	$45,501,800
Total	**$1,397,912,900**

Source: State Budget Office

Long-Term Care Adjustor Payments

A mechanism similar to the outpatient hospital adjustor was used to exploit room below the Federal UPL in Medicaid payments for long-term care (LTC) services. Between FY 1992-93 and FY 2004-05, the State provided payments to account for the difference between Medicaid reimbursement for nursing home and home and community-based waiver services and the Federal UPL to hospital chronic care units and county-owned medical care facilities. Facilities receiving this special payment returned the vast majority of the State share along with the Federal matching funds it generated back to the State through an IGT. The Federal portion of this payment was used to provide the State share of payment for other Medicaid services and represented GF/GP savings to the State. Table 4 provides a history of GF/GP savings generated to Michigan through use of this technique.

Table 4

LTC Adjustor Payments GF/GP Savings	
Fiscal Year	*Annual GF/GP Savings*
1992-93	$154,732,600
1993-94	$156,201,300
1994-95	$142,797,800
1995-96	$158,947,700
1996-97	$155,944,500
1997-98	$138,351,900
1998-99	$151,120,900
1999-2000	$363,320,900
2000-01	$406,798,000
2001-02	$376,045,600
2002-03	$330,953,100
2003-04	$212,130,500
2004-05	$115,136,900
Total	**$2,862,481,700**

Source: State Budget Office

Community Mental Health IGT

Between FY 1994-95 and FY 1998-99, the State made special payments to local Community Mental Health boards to account for the difference between Medicaid mental health reimbursement and the Federal UPL. These payments were structured like other adjustor payments, State matching funds were wired to the local public providers to account for this difference in payment rate, and then most of the State funds and the Federal match were returned to the State to support other Medicaid functions. This payment technique became unavailable to Michigan during FY 1998-99 as payment for Medicaid mental health in Michigan was modified to a managed care model. Table 5 provides a summary of the GF/GP savings Michigan enjoyed through use of this special payment.

Table 5

Community Mental Health IGT GF/GP Savings	
Fiscal Year	*Annual GF/GP Savings*
1994-95	$47,820,200
1995-96	$19,517,500
1996-97	$46,757,700
1997-98	$32,928,500
1998-99	$10,896,700
Total	**$157,920,600**

Source: State Budget Office

School-Based Services

In the early 1990s, changes in Federal law made it possible for schools to receive Medicaid reimbursement for services provided in schools. In response to this change in law, Michigan enrolled each of the intermediate school districts (ISDs) as a Medicaid provider. Schools receive reimbursement for direct health services like physical therapy, speech therapy, counseling and social work services, as well as reimbursement for administrative outreach (identification of Medicaid-eligible children, referral services).

The State is not required to provide any additional matching funds for these services; State and local funding used to support the employees providing the services is viewed as the non-Federal match. The ISDs file claims with the Federal government based upon the cost of providing these services to Medicaid-eligible children and the Federal share of the cost of the services is provided for these cases. The ISDs are not permitted to retain all of the Federal reimbursement for the school-based services but are provided only 60% of their reimbursement by the State. The State retains the remaining 40% of this reimbursement to support other Medicaid activities, so this portion of the Federal reimbursement drives the GF/GP savings in Medicaid. Table 6 below provides a history of GF/GP savings generated for the State of Michigan through retention of school-based services payments.

Table 6

School-Based Services GF/GP Savings	
Fiscal Year	*Annual GF/GP Savings*
1994-95	$17,052,000
1995-96	$42,546,400
1996-97	$70,367,300
1997-98	$69,156,800
1998-99	$81,634,300
1999-2000	$26,105,100
2000-01	$24,541,200
2001-02	$32,437,500
2002-03	$42,750,900
2003-04	$41,905,200
2004-05	$47,955,900
2005-06	$49,921,900
2006-07 (est)	$54,988,100
Total	**$601,362,600**

Source: State Budget Office

Certified Public Expenditures

In FY 2005-06, Michigan implemented a new technique to save GF/GP funds in the Medicaid program. A process known as certified public expenditure is used in partnership with public hospitals. The hospital submits documentation detailing its financial loss associated with uncompensated care, i.e., care provided to individuals without insurance or other means to pay. The State uses this information to submit a request to the Federal government to receive reimbursement for the equivalent of Federal financial participation for these services if they were covered through Medicaid. Federal reimbursement then is used to offset GF/GP expenditure in the Medicaid program. Table 7 details the GF/GP savings realized through use of this technique in FY 2005-06 and anticipated savings in FY 2006-07.

Table 7

Certified Public Expenditures GF/GP savings	
Fiscal Year	*Annual GF/GP Savings*
2005-06	$41,900,000
2006-07 (est)	$34,000,000
Total	**$75,900,000**

Source: State Budget Office

GF/GP SAVINGS FROM SPECIAL FINANCING

The summary of special financing techniques provided above demonstrates the lengths to which the State went to lower its GF/GP exposure in the Medicaid program. As Table 8 demonstrates, Michigan was successful in using special financing to hold down State cost in Medicaid. From FY 1990-91 to FY 2006-07, Michigan was able to generate nearly $8.0 billion in extra Federal reimbursement above what otherwise would have been expected from the State's base Medicaid program.

Table 8

Total GF/GP Savings to Medicaid by Technique		
Payment	*Years*	*Total Savings*
Public Hospital DSH	90-91 to 04-05	$1,432,708,700
Psychiatric DSH	94-95 to current	$1,399,105,200
Outpatient Hospital Adjustor	93-94 to 04-05	$1,397,912,900
LTC Adjustor Payments	92-93 to 04-05	$2,862,481,700
CMH Intergovernmental Transfer	94-95 to 98-99	$157,920,600
School-Based Services	94-95 to current	$601,362,600
Certified Public Expenditures	05-06 to current	$75,900,000
Total		**$7,927,391,700**

Source: State Budget Office

The benefits of special financing become more apparent when GF/GP savings for all special financing are presented by year: GF/GP annual savings topped $500.0 million between FY 1995-96 and FY 2002-03, with a high of nearly $800.0 million. As Table 9 shows, the growth of these savings coincides with the large budget surpluses Michigan enjoyed in the late 1990s, and the loss of special financing mirrored revenue difficulties experienced by the State over the past five years.

Table 9

Total GF/GP Savings to Medicaid by Year	
Budget Year	*Annual GF/GP Savings*
1990-91	$200,000,000
1991-92	$233,500,000
1992-93	$410,256,500
1993-94	$493,452,900
1994-95	$497,705,900
1995-96	$507,766,800
1996-97	$523,049,500
1997-98	$507,248,600
1998-99	$511,506,600
1999-2000	$744,887,600
2000-01	$782,497,500
2001-02	$732,937,300
2002-03	$615,391,000
2003-04	$496,191,600
2004-05	$329,875,400
2005-06	$172,128,400
2006-07	$169,006,600

Source: State Budget Office

The availability of special financing, especially in the mid- to late 1990s, may have distorted decisions about appropriate levels of State government expenditure and taxation. Assumptions about Medicaid spending (issues like covered populations and provider reimbursement rates), overall State spending, and the proper levels of taxation necessary to support State programs may have been skewed by the enhanced Federal revenue for Medicaid that these payment techniques made available. As changes in Federal regulations have limited Michigan's ability to generate special financing revenue, adjustments in spending priorities have become necessary.

State policy-makers attempted to mitigate the impact that losses of special financing would have upon State revenue by creating the Medicaid Benefits Trust Fund (MBTF). The FY 1999-2000 Department of Community Health appropriation established the Trust Fund and deposited nearly $240.0 million in adjustor payment revenue into the Fund as a hedge against future Medicaid revenue losses. Special financing savings also were deposited into the MBTF in FY 2000-01 (about $215.0 million) and FY 2001-02 (about $95.0 million). This revenue was used to help blunt the impact of the loss of special financing that started to become significant between 2002 and 2005.

THE ROLE OF SPECIAL FINANCING CHANGE IN GF/GP GROWTH IN MEDICAID

A great deal of attention has been given to GF/GP growth in Medicaid in Michigan since 2002. During this period, significant increases in program caseload, medical inflation, and federally mandated rate adjustments for managed care providers have necessitated annual increases of hundreds of millions of dollars in GF/GP support for the Medicaid program. This increased need for funds to support Medicaid is especially troubling because economic difficulties in Michigan have reduced the amount of revenue available for the operation of State government.

A factor that accounts for a portion of increased State Medicaid spending, and that receives little discussion, is the GF/GP cost associated with Federal changes that have reduced Michigan's ability to increase Federal financial participation in the Medicaid program. Table 10, below, illustrates the impact that the loss of special financing has had in exacerbating cost increases in Medicaid in recent years.

Table 10

Special Financing Change in GF/GP Expenditure for Medicaid

Year	Increase in State Medicaid Expenditure	Annual Change in Special Financing Savings	Change in State Medicaid Expenditure w/o Special Financing
1998-99	$165,282,300	($4,258,000)	$169,540,300
1999-2000	$82,427,500	($233,381,000)	$315,808,500
2000-01	$54,801,400	($37,609,900)	$92,411,300
2001-02	$11,360,800	$49,560,200	($38,199,400)
2002-03	$324,639,000	$117,546,300	$207,092,700
2003-04	$337,703,800	$119,199,400	$218,504,400
2004-05	$453,159,200	$166,316,200	$286,843,000
2005-06	$300,307,700	$157,747,000	$142,560,700
2006-07 (est)	$177,609,600	$3,121,800	$174,487,800

Source: Senate Fiscal Agency estimates

Table 10 shows how the loss of special financing increased necessary adjustments in State expenditure for Medicaid by between $117.5 million and about $166.3 million for each year between FY 2002-03 and FY 2005-06. Earlier years on the table also suggest that increases in available special financing revenue may have shielded the State from large increases in Medicaid cost.

If Medicaid special financing is taken out of the historic cost data altogether (in other words, it is assumed that all special financing savings in Michigan were actually financed with State GF/GP funds), there is a better indication of what portion of recently observed increases in Medicaid expenditure is linked to the loss of special financing.

Table 11, below, compares estimates of annual increases in State Medicaid expenditure between FY 1998-99 and FY 2006-07 with estimates of what these increases would have been if the State never had access to special financing. The table highlights the difference in percentage increases between observed changes in Medicaid expenditure since FY 2002-03 and what these increases would have been without special financing.

Table 11

State Medicaid Expenditure GF/GP Increases				
Year	Increase in State Medicaid Expenditure	Total Increase w/o Medicaid Special Financing	% Increase in State Medicaid Expenditure	% Increase w/o Special Financing
1998-99	$165,282,300	$169,540,300	8.8%	7.1%
1999-2000	$82,427,500	$315,808,500	4.0%	12.3%
2000-01	$54,801,400	$92,411,300	2.6%	3.2%
2001-02	$11,360,800	($38,199,400)	0.5%	(1.3%)
2002-03	$324,639,000	$207,092,700	14.7%	7.1%
2003-04	$337,703,800	$218,504,400	13.4%	7.0%
2004-05	$453,159,200	$286,843,000	15.8%	8.5%
2005-06	$300,307,700	$142,560,700	9.1%	3.9%
2006-07 (est)	$177,609,600	$174,487,800	4.9%	4.6%
2002-03 to 2006-07	*$1,593,419,300*	*$1,029,488,600*	*72.3%*	*35.1%*

Source: Senate Fiscal Agency estimates

Major changes in GF/GP need for Medicaid started becoming apparent in FY 2002-03 and have continued to the present day. In that time period, estimated State GF/GP expenditure for Medicaid has increased by nearly $1.6 billion (over 70%). The same calculation of Medicaid increase when one assumes no access to special financing at any time is still quite significant, an increase of over $1.0 billion, but the proportional increase, at about 35%, is nearly cut in half.

These figures suggest two things: first, that the loss of special financing has been a key contributor to increased GF/GP need for Medicaid; and second, that prior to FY 2002-03, use of these techniques shielded the State from GF/GP expenditure for Medicaid to support the program adequately.

Table 12 provides some perspective on how Medicaid expenditure, as a proportion of total State spending from State resources, has changed since FY 1998-99. These figures are once again compared to estimates of State Medicaid expenditure if special financing savings were not available and were filled with State GF/GP dollars.

Table 12

State Medicaid Expenditure Compared to Total State Spending from State Resources					
Year	Total State Medicaid Expenditure	Total State Medicaid Expenditure w/o Special Financing	Total Expenditure of State Resources: All Budgets	% of State Spending Medicaid	% of State Spending Medicaid w/o Special Financing
1998-99	$2,053,932,700	$2,565,439,300	$23,312,542,200	8.8%	11.0%
1999-2000	$2,136,360,200	$2,881,247,800	$24,590,658,600	8.7%	11.7%
2000-01	$2,191,161,600	$2,973,659,100	$25,714,870,900	8.5%	11.6%
2001-02	$2,202,522,400	$2,935,459,700	$26,086,792,200	8.4%	11.3%
2002-03	$2,527,161,400	$3,142,552,400	$26,020,543,200	9.7%	12.1%
2003-04	$2,864,865,200	$3,361,056,800	$26,570,970,800	10.8%	12.6%
2004-05	$3,318,024,400	$3,647,899,800	$26,285,288,900	12.6%	13.9%
2005-06	$3,618,332,100	$3,790,460,500	$27,704,032,200	13.1%	13.7%
2006-07	$3,795,941,700	$3,964,948,500	$27,928,557,000	13.6%	14.2%

Source: Senate Fiscal Agency estimates

Again, when special financing changes are taken into account, the major changes observed in Medicaid's role in State spending are not as pronounced as they otherwise would be. Between FY 1998-99 and FY 2006-07, Medicaid's portion of total State spending increased by nearly 5.0%, a significant shift in how State resources are allocated and the reason that many have rightly concluded that Medicaid has "crowded out" other State spending priorities. When this figure is compared to an estimate of changes in Medicaid's role in State spending without special financing, the increase is still quite significant but not as pronounced (about 3.0%).

It should also be noted that State Medicaid expenditure after FY 2001-02 includes revenue generated through Medicaid Quality Assurance Assessment Programs (QAAPs). A QAAP is a tax imposed upon certain Medicaid providers; revenue from the tax is used to create GF/GP savings to the State and to fund the State share of Medicaid provider rate increases for the taxed provider group. Revenue from this tax (over $2.5 billion since FY 2001-02) also plays a significant role in the growth in State Medicaid expenditure as a proportion of total State spending.

CONCLUSION

Since 1990, the State of Michigan has seen a GF/GP benefit of nearly $8.0 billion because of special Medicaid financing techniques. This paper has demonstrated that the loss of the benefit associated with these techniques has been a major factor in Medicaid cost increases over the previous five years.

Medicaid's structure as a matched program means that states are usually forced to make decisions on spending issues related to Medicaid (covered populations and services as well as provider payment rates) with an understanding that each additional dollar allocated to the program will require state financial participation at the FMAP rate. Use of special financing through the 1990s and the early part of this decade blunted the effective matching requirements on Michigan by drastically increasing Federal financial participation in the Medicaid program. This enhanced level of Federal Medicaid support may have influenced some of the spending and revenue decisions made in Michigan during this time, contributing to some of the structural budget problems that have been observed over the past five years.

As the Federal government has become more proactive in disallowing use of special financing payments, Michigan has been forced to realign its Medicaid spending to fit the State's FMAP and available revenue. This shift, combined with the cost pressures associated with the provision of health coverage, means that support for Medicaid will continue to be one of the major factors in the creation of future budgets in this State.

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